DENTAL BOARD OF CALIFORNIA
1432 HOWE AVENUE, SUITE 85, SACRAMENTO, CA 95825-3241
TELEPHONE: (916) 263-2300 FAX: (916) 263-2140
www.dbc.ca.gov

ORAL & MAXILLOFACIAL SURGERY
ELECTIVE FACIAL COSMETIC SURGERY
PERMIT APPLICATION

Business and Professions Code, Section 1638-1638.5

Office Use Only
Receipt No. _____ ATS #: _____
Fee Paid: _____ Initials: _____
OMS Permit #: _____ Issued: _____
Exp. Date: _____

NON-REFUNDABLE FILING FEES
Application $500

Full Name: _____

Address of record: _____

Practice Address (if different): _____

Telephone Number: _____

CA Dental License Number(s): _____ Date Issued: _____

Dental License Number: _____ State(s) of Issuance: _____

Elective Facial Cosmetic Surgery Permit Qualifications: (Complete 1, 2, and 3, choosing to complete either option 2A or 2B)

1. Oral and Maxillofacial Surgery Residency Program accredited by the CODA of the ADA:
Dates Attended: _____
Please include proof of certification of completion of a CODA-approved residency program.

2. Option A: (i)American Board of Oral and Maxillofacial Surgery Status:
Date Certified: _____

Re-certification Date: _____

Candidate for Certification: _____

Enclose proof of certification or candidacy for certification by the American Board of Oral and Maxillofacial Surgery.

(ii)Residency Program Director: _____
and/or
(ii)Fellowship Program Director: _____

Enclose a letter either from the residency program director and/or from the director of your CODA-approved post-residency fellowship program, stating that you have the education, training, and competence necessary to perform the surgical procedures that you are requesting the permit for and intend to perform.

(iii)Operative Reports:
Submit documentation of **at least 10 operative reports** from residency training or proctored procedures that **are representative of procedures that you intend to perform** from the following categories:

(I) **Cosmetic contouring of the osteocartilaginous facial structure**, which may include, but is not limited to, rhinoplasty and otoplasty.
(II) **Cosmetic soft tissue contouring or rejuvenation**, which may include, but is not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.

(iv)Surgical Privileges
Submit documentation showing all of the surgical privileges that you possess at any licensed general acute care hospital and any licensed outpatient surgical facility in this state.

I request a permit for : I Cosmetic contouring of the osteocartilaginous facial structure ❑
II Cosmetic soft tissue contouring or rejuvenation ❑

or limited to: _____
_____
_____
_____

2. Option B: (i)Specific Surgical Privileges

Submit documentation showing the privileges granted to you by the medical staff at a licensed general acute care hospital to perform the surgical procedures in the categories of:

(I)Cosmetic contouring of the osteocartilaginous facial structure, which may include, but is not limited to, rhinoplasty and otoplasty.
(II)Cosmetic soft tissue contouring or rejuvenation, which may include, but is not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.

(ii)Operative Reports:
Submit documentation of **at least 10 operative reports** from residency training or proctored procedures that **are representative of procedures that you intend to perform** from both of the following categories:

(I) **Cosmetic contouring of the osteocartilaginous facial structure**, which may include, but is not limited to, rhinoplasty and otoplasty.
(II) **Cosmetic soft tissue contouring or rejuvenation**, which may include, but is not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.

I request a permit for : I Cosmetic contouring of the osteocartilaginous facial structure ❑
II Cosmetic soft tissue contouring or rejuvenation ❑

or limited to: _____
_____
_____
_____

3. Active Staff Status of an Acute Care Hospital

Submit documentation showing proof of your active status on the staff of a general acute care hospital and that you maintain the necessary privileges based on the bylaws of the hospital to maintain that status.

Certification – *I certify under the penalty of perjury, under the law of the State of California that the information in this application and any attachments are true and correc*t.

_____ _____

Applicant's Signature Date

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by Dental Board of California, 1432 Howe Ave, Suite 85, Sacramento, CA 95825, 916-263-2300, in accordance with Business & Professions Code, §1600 et seq. Except for Social Security numbers, the information requested will be used to determine eligibility. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Disclosure of your Social Security number is mandatory and collection is authorized by §30 of the Business & Professions Code and Pub. L 94-455 (42 U.S.C.A. §405(c)(2)(C)). Your Social Security number will be used exclusively for tax enforcement purposes, for compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination board, and where licensing is reciprocal with the requesting state. If you fail to disclose your Social Security number, you may be reported to the Franchise Tax Board and be assessed a penalty of $100. Each individual has the right to review the personal information maintained by the agency unless the records are exempt from disclosure. Applicants are advised that the names(s) and address(es) submitted may, under limited circumstances, be made public.